# KANSAS MEDICAL JOURNAL.

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## ORIGINAL ARTICLES.

### The Toxine of Syphilis.

BY HENRY ALFRED ROBBINS, M.D., WASHINGTON, D.C.

Clinical lecture delivered at the South Washington (D.C.) Free Dispensary, April 3, 1897.

To-day we call your attention to the toxine of syphilis. It is generally admitted that the virus of syphilis depends upon an organism, and that after it has gained entrance into the body, it increases indefinitely. The cutting out or destroying the point of inoculation does not prevent the spread of the disease. It has been absorbed by the lymphatics, and then through the blood is distributed to every tissue of the body. As in other diseases caused by bacteria, such as septicemia, certain symptoms occur, showing that the entire system is poisoned. This poison is the product of bacteria.

Dr. Green, in his book on "Pathology and Morbid Anatomy, 1895," writes: "Albumoses are common intermediate products in the sequence of bacterial reactions. In some cases they are the most virulent of all the resulting compounds. This is so in diphtheria and in snake poison. In anthrax and cholera, on the other hand, they are comparatively of slight importance. Among the varied products of bacterial growth are a large number of alkaloid substances; some of these are harmless, but some are poisonous. The latter are known as toxines. Examples of both these varieties may be found in putrefying meat, fish and cheese. they can be easily separated, and their nature investigated. The virulence of both anthrax and cholera is due to the formation of toxines."

The toxine of syphilis varies in virulency according to the soil in which it is implanted. Some have the disease so mildly as to recover without treatment. Others having acquired the disease from the same source, are poisoned in the most malignant manner, and go from bad to worse, in spite of the most approved treatment.

The diagnosis of syphilis having been made, the patient can be assured that the long-continued and intermittent administration of drugs will prevent the formation, or destroy and eliminate from the system the toxine or poison of syphilis.

There is no antitoxine for the syphilitic poison. The man who indulges his licentious passions and breaks the Seventh Commandment must take the risks. The disciples of Auziae Turenne thought that "syphilization" would do for the great- what vaccination did for the smallpox. That it would make them immune. I have told you that their hopes were blasted. So it will be with the antitoxine treatment, for the reason that all animals are already immune, rendering it impossible to procure the antitoxine through them. Very numerous efforts have been made to impart syphilis to the brute creation.

Dr. Rebatel, in the *Lyons Medical Journal*, January 8, 1882, gives an interesting account of how he recently had been making a series of experiments on animals, with a view to test anew the question, whether or not they are susceptible to any of the several veneral diseases of mankind. His subjects were dogs, rabbits and guinea-pigs. No trace of consecutive inflammation was ever seen. Another series of experiments was performed with material from a soft chancre; the results were negative, as in the former case. Finally he took two hard chancres, that had been removed in the operation of

circumcision; then making slits in the inguinal folds of a bitch, he inserted them, sewing up the openings. No symptoms of infection followed. Into the jugular vein of a dog, he next injected one hundred and fifty grammes of defibrinated blood, taken from a patient in the full tide of secondary syphilis. No ill symptoms followed, but in due course of time these two animals contributed mutually to the production of a litter of puppies, twelve in number. Nor did these young manifest any congenital disease, or in fact anything but the most exuberant health.

In 1883, my friend and former professor, Dr. Isidor Neumann, of Vienna, made a number of attempts to inoculate animals with syphilis, but without success. In no case did any results follow other than those which would naturally appear on introduction of an irritating material into the tissues. Neumann concluded from these experiments that we must regard syphilis as distinctly a disease of man.

These experiments were made on animals long before the antitoxine treatment was thought of. We knew that measles, or scarlet fever, or smallpox, as a rule, occurred but once.

Edward Jenner was the first to carry out the idea of making human beings immune from the smallpox by means of vaccination. Pasteur was the first to experiment on animals, resulting in the discovery of the antitoxine for hydrophobia. You will say, as animals are immune to syphilis, then their serum is already antitoxine to the poison of syphilis. Why not use that? It has been tried. I will relate the experiments of various syphilographers, as reported by Mueller-Kanneberg in the *Archives fur Dermatologie and Syphilologie*, 1896.

Kollman, in 1890, was the first to make use of the serum of animals in syphilis. In 1892 Tomasoli recorded a brilliant success in six cases of recent syphilis, treated by the injection of lamb's serum. Heircourt and Richel have recorded favorable results, while others have been totally unsuccessful.

Experiments were made on twelve patients at Lewis' clinic in the Charite at Berlin, and the results are described in Mueller-Kannberg's paper. The serum was obtained from horses, a source that has never been made use of in syphilis. As a preliminary trial, two patients were given an injection of five cubic centimeters of the serum. Their general condition remained unaltered, but five days later each experienced an attack of urticaria which lasted seventeen days. Another patient treated in the same way developed such grave symptoms that no further trial was made. In the remaining cases no positive influence on the syphilitic process could be claimed. Urticaria was almost universally produced, sometimes of an exceedingly annoying and obstinate type. Some of the patients received at intervals as much as five injections without effect upon the disease. The writer remarks, in conclusion, that no encouraging deduction can be drawn from these experiments, which are the same as those of Kollman. The urine in these cases remained normal.

Professor Neumann, of Vienna, has recently been carrying on a series of investigations on the treatment of syphilis by the serum of animals immune to this affection, but with the results far from being satisfactory. The ordinary methods still show the best results. He pleads that the number of his cases was too few to condemn the method, especially as other "syphilographers" have met with some success; therefore, he would recommend a continuance of the experiments.

In the *Archives fur Dermatologie und Syphilologie*, Prof. Tornowski, of St. Petersburg, related his experiments with the serum treatment of syphilis, and is reported as follows: "Reflecting upon the absence of positive results from employing the normal serum of animals, that of animals inoculated with syphilitic products, or that of persons affected with constitutional syphilis, Tornowski thought it most rational to use serum obtained by a process as nearly as possible the same as the one employed in the preparation of antidiphtheritic serum; but the practical difficulty presented itself of finding an animal susceptible to syphilis. However, he thinks he has found such an animal in the foal. Although, on inocula-

tion, the foal does not show any outward signs of syphilis, changes extraordinarily like those due to that disease are found in different internal organs, and in the blood vessels and the lymphatic glands in the course of two or three months. Accordingly he has endeavored to syphilize two foals with moist syphilitic papules by implanting them in incisions into the skin, by applying them to a blistered surface, and by injecting an emulsion of them subcutaneously. After these inoculations had been many times repeated, blood was drawn from the animals, and the serum was administered subcutaneously to six patients, usually in doses of from ten to twenty cubic centimeters. In five of the patients the disease was quite recent and had not been treated before; the remaining one had tertiary manifestations. The therapeutic result was nil, even after long persistence in treatment; the cases followed their course precisely as if no treatment had been practiced. Moreover the injections seemed to have had a detrimental effect. Three of the patients lost flesh, their general health grew worse and they had transitory albuminuria. In four cases an itching erythema appeared, with pains in the muscles and joints, also purpura in two instances. When large doses were used the temperature was decidedly raised."

Gilbert and Fournier (*Semaine Medicale*) inserted under the skin of certain animals the serum of the blood, chancres and papules obtained from patients suffering from primary and secondary syphilis, with the object of increasing the natural antagonism of the blood of these animals to the syphilitic poison.

The patients treated by the serum obtained from the animals thus prepared were seventeen in number. Of these, seven underwent the usual anti-syphilitic treatment concurrently with the serum injections. All improved; but the authors hesitate to ascribe much force to these cases. The results on the other ten cases were contradictory. While some of them showed marked improvement under the treatment, others appeared to be influenced by it. A patient may be instanced who presented at the commencement of the treatment three cicatrixed preputial chancres, roseola confluens and headaches, worse at night. In the space of twenty days he received forty-eight cubic centimeters of serum in seven injections. The roseola paled, but nevertheless persisted; hence, although the man's other symptoms and general condition were favorably influenced, the authors are inclined to regard the results as negative. Farther researches are in progress.

You will say that the so-called tertiary stage is the product of bacteria. It is the toxine of syphilis. The cases of reinfection are so uncommon that the victims of syphilis are considered to be immune against another attack of the disease. Why not take the serum from one already suffering from tertiary syphilis! This has been done, and experiments are still being made. Gilbert and Fournier, adopting the method of Pellizzari, took the serum obtained from the blood of a patient with a clear history of old syphilis and suffering from tabes, but in a very satisfactory general condition, and from another patient who had had gummata and was under treatment for obstruction of the vena cava superior. The subject of the experiment was a patient until then untreated, having two infecting chancres on the penis, double buboes, anemia, headache at night, aching in the joints and bones and a general maculo-papular eruption, most intense on the trunk. He received three hundred and four cubic centimeters of serum in twenty days, the average dose being 35 cubic centimeters. During that time the chancres cicatrized, his pains vanished, the general condition was much ameliorated and the eruption disappeared, except a slight lingering roseola. The eruption was earliest influenced and soonest gone on the front of the abdomen at about the level at which the injections were made. This local action was very striking.

Cotterell (*Medical Press and Circular*, August 28, 1895,) states that he has treated eighteen cases of syphilis by injection of the serum of blood of patients who had gone through an attack of syphilis and were rendered immune. He does not state

the age of the disease, nor of the patient or patients from whom he obtained the serum, nor are any details given. The treatment was pursued over six months. The conclusions are as follows, viz.: In the early stages of syphilis, *i. e.*, when there is only a sore and glandular enlargement, injections of this serum cause the sore to heal rapidly. The adenitis in the groin generally becomes intensely marked; the skin and throat symptoms are absent or only slightly marked. When the case is not seen until the rash and throat symptoms develop, the skin eruption fades more rapidly, as a rule, then under mercurial treatment, but the throat symptoms disappear rather slowly. The general health improves. The serum from an individual with well marked secondary syphilis appears to be more active than that obtained from a patient with tertiary symptoms. The author has not yet accurately determined the amount to be injected, but he has used the serum in doses from ½ to 5 cubic centimeters.

Boeck, since November of 1894 (*Archiv fur Dermatologie and Syphilologie*, July 3, 1896), has treated seven patients by injections of the hydrocele fluid drawn from a man in the sixth year of syphilis. This fluid was filtered before being injected. He was astonished at the results. The first case received in all 6½ drachms of the serum. Eight days before the time the secondaries should have developed, the injections were begun, a drachm being employed every second day. The large chancres and the marked swelling of the glands disappeared promptly. Although the exanthema appeared after the regular time, it was very slight and lasted only a few weeks. There were only a few mucous patches. The second case was given serum injection sixty days after infection; from fifteen to sixty minims were employed at a time; in two months all secondary symptoms had disappeared. Similar improvement was noted in all the cases. He holds that the effect of this treatment is observed in the quick disappearance of the primary symptom, the abortion or marked amelioration of all secondary symptoms and the improvement in general condition. The treatment is potent in proportion to the promptness with which the injections are begun. The serum treatment is not as prompt and evident in its effects as iodides and mercury, but it is more rational.

Tommasoli (*New York Medical Journal*, September 26, 1896,) took the ascitic fluid of a person affected with syphilitic disease of the liver. This he employed upon seven patients in the tertiary stage, most of whom had had no previous specific treatment. The smallest number of injections given in any one case was eight and the largest thirty-seven, in periods ranging from ten to fifty-seven days, and the total amount injected varied from 68 to 350 cubic centimeters. The fluid was obtained with all antiseptic precautions and used either fresh or after being kept in sterilized vessels with the addition of a few drops of chloroform; it was injected into the buttocks and no serious mishaps occurred in any case. In most patients, soon after the injection, there followed indisposition, headache, giddiness, etc., but these disturbances always subsided speedily. No albumen was ever found in the urine. As to the effect on the disease, all that can be said with certainty is that new symptoms made their appearance during the course of injections.

Tommasoli also used the milk of two women who had secondary syphilis—latent in one of them. After proper cleansing of the nipples the milk was pressed out and injected immediately into the muscles of the buttock. Of seven patients treated by this method, one had gummatous syphilis, but all the others were in the secondary stage. The number of injections varied from three to thirteen; and the total amount injected into any one patient ranged from 30 to 100 cubic centimeters. Ten of the patients in the secondary stage were decidedly improved; the others showed no change. This method was based on the observation that in other infectious diseases, such as tetanus and diphtheria, the antitoxines pass into the milk.

The result of these experiments show that tertiary products, such as fluids obtained from a syphilitic hydrocele and ascitic fluid

result of syphilitic liver disease when injected into the tissues of the body, have a curative action upon constitutional syphilis. Cotterell goes farther and says: "The serum from an individual with well marked secondary syphilis appears to be more active than that obtained from a patient with tertiary symptoms."

Suppose we take it for granted that we have an antagonistic virus and some young man comes along and wants to be immunized against syphilis. If we were to inject a tertiary product perhaps it would do no harm. Should we take the serum, or blood, or pus from a mucous patch, we would have as a result a chancre at the point inoculated. Galligo, of Florence, experimented on himself, taking the pus from a mucous patch. The result was a chancre which developed seventeen days after, followed by roseola, etc. Likewise, where syphilitic blood was inoculated, as in the case of Dr. Bargioni, who voluntarily submitted to be experimented upon with the blood of a syphilitic woman.

No Jenner has appeared with his magic wand to do with the great- what that great man did for the smallpox.

## Conveyance of Tuberculosis.

Berlin letter in Medical News.

Some time ago, Professor Flugge, the Director of the Institute of Hygiene at Breslau, announced, as the result of a long series of experiments, that the ordinarily accepted mode of the conveyance of tuberculosis is not the true one. One of his conclusions was that dried sputum rubbed into dust, and blown around in the atmosphere is not only not an evident mode of contagion in tuberculosis, but that it is even improbable. For him the consumptive loosens from his infected mucous membranes during a spasm of coughing, numbers of bacilli, and disseminates them in the atmosphere. The coughing act is really an atomization of pulmonary secretion. To the resulting minute particles bacilli are attached, and float hours in the air surrounding the coughing patient. This theory contradicts a good deal of clinical experience in the matter of liability to contract the disease on the part of nurses and others who are during long periods in close association with such patients, and has not been published without a good deal of protest. It is admitted that Professor Flugge's experiments have thrown new light on the dissemination, and that his presentation of the subject in so striking a manner cannot but have a good effect in the increase of prophylactic measures. On the whole, however, it is urged that there is an incompleteness in the artificial comminution of tuberculous sputum for experimental purposes which does not hold good in natural processes.

A recent writer has called attention to the fact that a very simple series of experiments will throw a good deal of light on the subject. As guinea-pigs are very susceptible to tuberculosis, he suggests that one of these animals be kept close to the bed of a phthisical patient, but with the most careful precaution to prevent contamination of its food and drink. The resultant mortality and the manner of death will greatly aid in the solution of a very interesting and very practical question.

## Inferior Maxillary Fracture.

Boston Medical and Surgical Journal.

Moriarity says: Impressions of both jaws are taken, the fractures being unreduced; and plaster casts indicating the line of fracture which is severed by a fine saw are made. The deformity is then corrected and a vulcanite splint, from each side of which a wire projects, is made; these wires are joined behind the head by a bandage. The jaws are fitted to the splint and a bandage connecting the side wires is run under the chin to support the jaw. When greater pressure is desired, a metal chin piece, fastened to the side wires by screws, may be utilized. If the symphysis be the seat of fracture a continuous cap of gold or aluminum may be cemented to the lower central teeth.

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## Topeka, Kansas, Saturday, Dec. 25, 1897.


As we approach the beginning of a new year there is a consciousness of the incompleteness of things. What we have failed to accomplish during the past year we faithfully promise ourselves will be done before the end of another. In this great field of medicine how much can we say has been perfected during the past and how near in the future can we say that even a small part of medical science will be made perfect. All we can say is: that this great science has made one step farther along the road toward a perfect conception of the intricate mysteries of human life; that its light has penetrated deeper into the labyrinths of the unknown, and that it has moved still nearer a perfect realization of the hopes and ambitions of those whose lives are devoted to the relief of human ills.

What may be accomplished along the line of progress during another year depends upon the determination of each and every individual. Through the ambition for great attainment in medicine and the struggle for existence, many things which might have been accomplished for the welfare of the profession have been neglected or overlooked. Much might be done to relieve the burden of anxiety on the part of those who are forced into competition with quacks and pretenders. That the efforts of a few have failed does not signify that in unison there is not sufficient strength to accomplish much in this direction. Many benefits may be derived from a union of purposes and interests. A kite maintains its flight in the air by the cord with which it is held. Snap the cord and the kite soon falls to the ground. So no matter what may be our elevation in the medical world we should not forget the ties which bind us to the commoner things of earth lest we fall. Great development of the soul and mind must occasionally be lost sight of in selfish consideration of the body. And in our efforts to emancipate the strictly professional from the business side of our lives we are weakening that upon which our elevation is maintained. It seems to us that the practice of medicine as a business proposition is open to many improvements. It is proverbial that physicians are poor business men. Is it not time that we should make an effort to put the profession upon a more substantial footing? We have attempted to secure laws regulating the practice of medicine on the representation that it was for the benefit of the people. Why not recognize the fact that such a law is essentially for our own benefit and demand it? Why not demand a law which makes a bill for medical services a preferred claim and not subject to exemption? Why not demand a law providing for reasonable expert witness fees? Would such demands avail anything? If they should come from a few of the leaders in the profession backed up by the influence of a few lobbyists? No! But if they should come from the 3,000 physicians in the State of Kansas backed up by their combined strength and influence? Yes.

## The Administration of Phosphate of Strychnia During Gestation.

Medical Review of Reviews.

Walter Blackburn Dorsett, M.D., St. Louis, Mo., recommends this drug in a communication to *The American Journal of Obstetrics*, given in the form of a gelatin-coated pill gr. 1-100, and gradually increasing the dose to gr. 1-25, if deemed advisable. He says:

"The followidg observations have been made by me in the use of phosphate of strychnia during the gestation of weak and debilitated patients: A good appetite and a good assimilation are obtained in the general weakness and debility of the anemic, constipation is relieved, and, in short, the patient is built up and placed in a good condition to pass through the ordeal of labor; the uterus contracts promptly after the third stage of labor, and the use of ergot is entirely dispensed with. In this connection I wish to say that it has now been five years since I have used any ergot in my obstetrical practice. If I find it necessary to use forceps the patient is given a hypodermatic injection of one-thirtieth of a grain of sulphate or phosphate of strychnia as soon as the anesthetic is commenced, but no ergot is ever used. I have also observed that after the continuous use of the phosphate of strychnia the uterus contracts promptly after the second stage of labor; and in many cases the application of Crede's method of expression of the placenta is not needed to bring it away, and no post-partum hemorrhages have occurred. The often observed chilliness or rigors which in the majority of cases follow labor have been noticed in but few cases. These rigors, so common after labor, an account of which little can be found in the text-books, is nothing more no less than surgical shock. This is obviated by the prophylactic—strychnia.

"I have used strychnia for some time in my abdominal surgery for the purpose of preventing shock and to control the pulse in operations, and in this way was led to its use in obstetrics.

"In closing I wish to say that, as phosphorous and strychnia are remedies used in the treatment of rachitis with good results, would it not be the remedy during the gestation of the rachitic fetus?

"The phosphate of strychnia I have found to act better as a laxative than either the sulphate or nitrate."

## The Surgical Treatment of Epilepsy Its Indications and Consequences.

Medical Times.

At the International Congress of Neurology, of Psychiatry, Medical Electricity and Hypnology, held at Brussels, Sept. 14–19, 1897, M. Winkler, Amsterdam, reported the following conclusions:

1. Reflex and topical epilepsy may present unilateral or local spasms, the same with traumatic epilepsy, and that due to any other lesion, more or less circumscribed, of the brain. It is not then cortical epilepsy alone which begins with local or unilateral convulsions.

2. Every epilepsy is symptomatic, and a symptomatic epilepsy cannot be separated from a true or idiopathic epilepsy, and, consequently, epileptic surgery does not exist; it is that of the brain and the cranium.

3. An epilepsy may necessitate surgical intervention, in case only when the cerebral lesion permits the intervention, that is to say, when the lesion can be located with certainty, is accessible and sufficiently circumscribed to allow of complete extirpation.

4. That which I dominate a diseased condition—etat de mal—with unilateral spasms, preceded, accompanied, or followed by monoplegia or hemiplegia of the convulsed side, always indicates temporary extensive osseous resection of the opposite motor zone.

5. Circumscribed tonico-clonic spasm that acts as an initial symptom and signal of unio lateral or general convulsion or that constitutes the entire attack, with or without loss of consciousness, indicates surgical interference in case of visible wound of the cranium, provided there is a topographical identity between the wound and the center which is presumed to be the point of depar-

ture of the signal symptom.

6. In case of topographical difference between the exterior cicatric and the presumed motor center, or when the exterior traumatism is defective, the aura preceding the motor signal symptoms acquires, if it exists, an extreme value.

7. The sensorial aura of an extremity, in which the signal motor symptom begins, accompanied often by paralysis of muscular power, indicates a lesion of the parietal globe, posterior to the motor zone.

8. The visual aura, often connected with the preceding, and preceding, too, the signal motor symptom, in this case rotation of the eyes, and of the head toward the opposite side, and often accompanied with an incomplete hemianopsis of the inferior part of the visual field, presumes a lesion of the angular convolutions of the cuneus.

9. The aura of memory—aura intellectualis—often connected with an epigastric or an olfactory aura, and preceding the signal motor spmptom, induces suspicion of a lesion of the frontal lobe, especially the right.

10. The results obtained by surgical intervention in epilepsy are satisfactory when a lesion is absolutely reachable, and can be completely removed. The extirpation of a center, which exhibits no lesion to the naked eye, is not permissible, except in case it can be demonstrated that the center plays the role of a discharged lesion. At present, the only means of making this demonstration consists in reproducing by faradic excitation of the center an attack absolutely similar to spontaneous attacks.

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## Quacks and Gulls.

The Practitioner.

The following story, which I take from a French newspaper, well illustrates that particular twist in the brain of "this foolish-compounded clay man," which leads so many otherwise fairly intelligent folks to place more reliance on quacks than on qualified medical practitioners. In a fashionable quarter of Paris one "Alexis" does a roaring trade as a bone setter and herbalist. To him one fine day there came a commissioner of police with an invitation to follow him to his office. The quack took the matter quite coolly, and, while preparing to obey the summons of the law, said to his servant, "Don't send anyone away; I shall be back in a few minutes." The representative of the civil power hinted with a significant smile that his return might possibly be a little delayed. On arriving at the police office "Alexis" asked the commissioner for a moment's private interview. This, after some demur, was granted. When they were alone, "Alexis" took from his pocket a diploma of Doctor of Medicine of the most authentic character, at the same time begging the astonished commissioner not to betray his secret, on the ground that he would lose all his practice if it were known that he was a regularly qualified doctor. He added by way of explanation that he had tried practice in the orthodox way, and had nearly starved behind his brass plate. An inspiration came to him to start as a quack. He removed his plate, dropped his surname, gave himself out for a bone setter—and he might have added, pointing to his rooms crowded with patients, "*Si monumentum quoeris, circumspice!*" This interesting story carries its truth on its face. I do not know whether "Alexis," doctor though he be, has much knowledge of medicine, but he evidently knows mankind.

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## Pyopericardium.

Journal of American Medical Sciences.

Pyopericardium always demands pericardotomy. That a pericardial exudate is pus must usually be demonstrated by aspiration, preferably through the upper part of the left xiphoid fossa. If the symptoms be urgent and exudative pericarditis be confounded with cardiac dilatation, exploratory incision is justifiable.

As a result of his work on the cadaver, Roberts proposes the following operation for suppurative pericarditis: An incision one cm. to the left of the median line is carried from the upper border of the fourth costal

cartilage to the top of the sixth, along which it runs to meet an incision made parallel to the vertical part of the first, but four or five cm. to its left. The fourth and fifth cartilages are cut on the level to prevent their falling in when replaced, and the trap-door thus formed turned up. The triangularis sterni and pericardium are vertically incised, the pleura and the internal mammary vessels being pushed to the left, the sac drained by a double tube coming through the fourth or fifth space, and the trap-door replaced, the cartilages being sewn if necessary. Without operation practically all die; repeated aspiration is but little better. Of thirty-five cases treated by incision 43 per cent. have recovered.

## Premonitory Symptoms of Puerperal Infection.

Canada Medical Record.

Ferre (*L'Obstetrique*) lays stress on the success of intra-uteri treatment for puerperal fever. The success stands in direct ratio to the earliness of intervention. Hence very careful clinical researches have been made in lying-in hospitals in order to detect true prodromata. The true rigor, local pains and conspicuous pulse and temperature are known to all, and when combined indicate more or less advanced infection. Ferre denies that these symptoms ever come on suddenly, though certain milder types of infection now observed may represent sepsis modified by antiseptic agents. These milder types, however, will assuredly develop into deadly septic infection if neglected. Ferre finds, after long clinical research, that even the severest form is preceded for a day or two by distinct elevation of temperature and pulse, and by insomnia. An evening temperature of about 100° in the axilla, with a fall of about a degree in the morning, without a corresponding drop in a somewhat rapid pulse, is a distinctly suspicious symptom. The rise in the pulse often precedes the rise in the temperature; the observer must therefore make sure that acceleration of the heart's action is accounted for even in a patient who seems otherwise convalescent. Reaction after the fatigue of labor, hemorrhage and emotions all send up the pulse. Insomnia, Ferre has noted, is often observed in the earlier stages of infection, distinct want of sleep without restlessness is usual for a day or two before bad septic symptoms. The lochia may remain free from odor in the premonitory stage of puerperal septicæmia, nor are the discharges always fœtid when the disease is established.

## Non-Ligation of Umbilical Cord.

Canada Medical Record.

Kellar (*Pacific Medical Journal*) advocates non-ligation of the cord; he has practised it in more than 2,000 cases, and, after careful observation of these and other cases, summarises as his views:

1. Ligation in man is unnecessary because

(*a*) it is not required at birth of any other animal.

(*b*) the imagined necessity to prevent hemorrhage does not exist.

(*c*) to tie for cleanliness is superfluous.

(*d*) it is unreasonable to consider such an imperfection as need of ligature exists.

2. Ligation is in many cases injurious,

(*a*) because it may justly be considered the cause of secondary hemorrhage.

(*b*) by interfering with desication, and thus preventing separation, it gives rise to ulceration, with not infrequent consequences of erysipelas, fungoid excrescence, etc.

(*c*) it causes inflammation of funicular vessels by keeping them distended with unnaturally retained blood, hindering their normal obliteration, and laying foundation for phlebitis, jaundice, pyæmia, etc.

(*d*) by preventing normal escape of blood, and thus causing hyperæmia and congestion of portal circulation, it may lay the foundation of numerous infantile affections apparently originating in congestions of these vessels.

3. Certainly in some, and probably in not a few, cases ligature has been directly fatal,

(*a*) numerous fatal cases attributed to ligation have been recorded by the highest authorities,

(*b*) it can be seen in the newborn that the ligature maintains the right ventricle in a state of distension, otherwise relieved by bleeding from the hypogastric arteries, and this prevents renewal of action if the heart has stopped, or hastens its stoppage if it is failing,

(*c*) in many instances removal of the ligature has saved life when other remedies have failed.

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## The Case of Searle vs. Gurdon.

New York Medical Journal.

This is the subject of an editorial which appeared in the *Intercolonial Medical Journal of Australasia* for September 20, in which the writer, thinking it would be of considerable interest to the profession, gives a brief summary of the facts as follows:

The plaintiff, Searle, asked Dr. Gurdon, who is in practice in Brighton, to attend his wife. Dr. Gurdon found that Mrs. Searle was suffering from pelvic trouble which, in his opinion, required operative treatment. Dr. Balls Headley, who was called in consultation, confirmed this opinion, and performed abdominal section. The after treatment was conducted by Dr. Gurdon. The patient convalesced satisfactorily after the operation, but did not recover perfectly. Dr. Gurdon told the Searles that if, after some time, she was not perfectly well, it might be necessary to curette the uterus, and that, if it was, he would perform this operation himself without special fee. She appeared to progress satisfactorily, however, and went to another colony on a visit, and with Dr. Gurdon's approval. On her return, the Searles went to live in another district, and Dr. Gurdon ceased attendance. His account had not been settled, though a fee had been paid for the operation. He was then sent for to see Mrs. Searle for some temporary ailment, but was unable to go, and advised them to call in the nearest medical man. They accordingly called in Dr. Weigall.

Some time after, Searle called upon Dr. Gurdon and asked him to attend Mrs. Searle and curette her, as he had agreed to do, without fee. Dr. Gurdon declined, stating that he did not think it a proper proceeding. Searle then said Dr. Weigall thought it necessary.

Some communications then passed between Drs. Gurdon and Weigall, the former warning Dr. Weigall to be careful in his relations with the Searle, and declining to have anything more to do with them, Dr. Weigall urging Dr. Gurdon to curette, as the operation was necessary. Finally, Dr. Weigall operated; the Searles then requested Dr. Gurdon to pay the expenses thus incurred. Dr. Gurdon refused, the Searles brought the action in question for £500 damages, and Dr. Gurdon brought a counter action to recover his fees. The case lasted several days, and finally the jury awarded the Searles a farthing damages in the first case, and gave a verdict for them in the second case of counter claim. The judge refused to allow costs, as he interpreted the verdict to mean that the jury awarded contemtuous damages, and regarded the action as one that ought not to have been brought. The jury also added a most inconsequential and irrelevant rider, to the effect that medical etiquette was detrimental to the interests of patients, and and that the moral responsibilities of surgeons performing operations were not sufficiently evident.

Such, continues the writer, are the bare facts, upon which every member of the profession will probably make his own comments. The case well illustrates, he thinks, the risk medical men run in their daily practice, and the necessity of supporting medical defense associations.

It is not to be assumed, he goes on to say, for a moment that Dr. Weigall acted unprofessionally, but he certainly allowed himself to be placed in a very awkward position, and his conduct appears to be open to adverse criticism. Seeing that a difference of opinion existed as to the ex-

pediency of an operation, it would have been wiser to obtain a specialist's opinion before operating himself, especially under the peculiar circumstances. On the other hand, it may be said that Dr. Gurdon should have seen the patient with Dr. Wiegall and ascertained her condition at the time, before deciding that no operation was necessary, and had he done so, probably the case would not have come to the court.

Another moral to be drawn from this case, the author thinks, is the unwisdom of making contracts with patients. No doubt, he says, patients want to have some idea of what the total expenses of a case will be, and an approximate estimate can often be given. It is always better, however, to state the fees for operation, anesthetization and assistance separately, and to charge for after attendance independently, and the scale of fees adopted in various places provides for this, he adds.

The final result of this case, so far as Dr. Gurdon is concerned, says the writer, is that, while he has gained a moral victory, he has done so at great personal loss. The writer states that a meeting of the profession was to be held to sympathize with Dr. Gurdon. It is to be hoped, he remarks, it will be largely attended, and that those present will show that professional sympathy is not a mere sentiment, and that a practitioner who acts conscientiously, and in the interests of the profession, in refusing to allow patients to dictate to him what he should do, or to be coerced into what he does not think right, will not be allowed to suffer pecuniary loss in consequence.

## How to Secure Asepsis in Cases of Burns.

Columbus Medical Journal.

Dr. C. K. Cole, of Helena, Mont., states that of prime importance in the treatment of burns is the necessity of making the involved portion as nearly as possible aseptic. "To accomplisn this, the clothes having been removed in a warm room, all blebs should be punctured, shreds of clothing and other debris carefully washed and mopped with some mild germicidal solution, preferably borosalicylic solution, or the standard Thiersch's solution, the whole carefully enveloped in multiple layers, first of borated lint and absorbent cotton, covered with rubber tissue, with either bichlorid or iodoform gauze (constituting the outer layers) held in place lightly by a few turns of a roller bandage. Among the newer remedies applicable in these cases there is one much vaunted, and very justly so. I refer to europhen, which may be used in the form of powder, gauze, or a 3 to 5 per cent. ointment. With reference to the latter preparation (the ointment), while it is almost uniformly recommended, I seriously question whether its use is consistent with strict antisepsis. Europhen has the advantage over iodoform of being non-odorous, practically devoid of danger from toxic effects, and, according to some authorities, is better than iodoform in promoting rapid healing, especially in suppurating cases. The exclusion of atmospheric air is *sine qua non*."

## Forced Enemeta in the Treatment of Intussusception.

T. H. Hawkins, M.D., in Medical Record.

A little child, about eight months old, was brought into St. Anthony Hospital, by Dr. E. C. Hill of this city, June 16, 1897. Dr. Hill had already diagnosed intussusception. I made a careful examination, and confirmed his diagnosis. Dr. Leonard Freeman was asked to examine the child, and agreed with us as to the nature of the lesion. The child had been vomiting pesistently for about twelve hours, with no action of the bowels. A distinct mass could be felt in the right side of the abdomen, two inches above and about two inches to the right of the umbilicus. We advised laparotomy. Before doing the operation, however, Dr. Freeman suggested that it might be a good plan to inject one-half pint or more of warm water, and if this came away tinged with blood there certainly could be no doubt as to the correctness of our diagnosis.

The suggestion of an enema called to my mind several cases of this kind under my care during my residence in New York City, in the years 1874-76. In the latter year I read a short paper, containing a report of three cases of intussusception treated by forced enemata, before the Eastern Dispensary Medical Society. This article was published in the *Medical and Surgical Reporter*, December, 1876. These cases were successfully treated, and there was never a return of the trouble, so far as I have been able to learn. Two of the patients were under my observation for some five years afterward.

I therefore concluded to try the injection method in the present case. The child was placed across the nurse's lap on its abdomen, and its body allowed to hang head downward. The nozzle of a bulb syringe was inserted into the bowel and the buttocks were compressed tightly. The water was pumped in rather slowly at first, and was violently expelled; but gradually more force was used, and the water entered more easily. About one gallon was used in this way in from six to seven minutes. When the child had been placed in bed on its back, the tumor was again felt for, but could not be found. Dr. Hill, Dr. Freeman, and myself made a careful examination, and decided that the invagination had probably been overcome. The vomiting had gradually ceased, but there was no passage of fæcal matter for nearly twenty-four hours, though there was considerable discharge of blood and mucus. The child made a perfect recovery.

In the article published in the *Medical and Surgical Reporter*, if I remember correctly, I laid considerable stress on the necessity of using a large amount of fluid with a great deal of force. I also took the ground that there is practically no danger of rupture of the intestine; that, in fact, in cases of acute intussusception the invaginated portion of the intestine, on which the greatest strain is exerted, is also the strongest part of the gut, by reason of the reduplication.

I am lead more particularly to report this case because of an article published in the *Medical Record*, July 17, 1897, by Dr. C. L. Gibson of New York, entitled "Mortality and Treatment of Acute Intussusception." In this article the writer, in speaking of enemata, says that they are distinctly dangerous, and that the amount of pressure which can be used is very limited; that the quantity of water should not exceed one and one-half pints, and the pressure should not be greater than three feet. From this I infer that he uses the fountain syringe. The use of the fountain syringe will certainly not succeed nearly so well as the use of the bulb.

One other point in connection with this last case, namely, that water unquestionably found its way through and passed from the mouth of the child. I do not propose that forced enemata with fluids should be substituted for laparotomy in all instances. I merely call attention to this case and the report of my former cases, that they may be considered for what they are worth in the study and future treatment of intussusception.

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## Obstruction of the Small Intestine by a Gall Stone.

British Medical Journal.

Bradburry reports two cases of impaction of the small intestine by gall stones attended with symptoms of obstruction. The condition is a rare one, having been observed but once in the Manchester Royal Infirmary between the years 1883 and 1896, among fifty thousand in-patients, and only four times during twelve months in some of the largest hospitals in England, representing altogether eighty thousand in-patients and several hundred thousand out-patients.

The first case occurred in a man, 60 years old, and was complicated by the existence of cystitis and a general debilitated condition that rendered diagnosis almost impossible. The second occurred in a womon, almost 60 years old, in whom there was no symptoms until obstruction occurred. The one case terminated fatally, the other in recovery. In neither case was there a history of jaundice or colic, or of a similar previous attack. In one case the stone was about one and one-

half inches in diameter, and nearly spherical. In the other it weighed nearly one-half ounce, was almost two inches long, a little more than one inch in diameter, and had a circumference of three inches. In the second case no indication whatever of any hepatic disturbance existed, and until symptoms of obstruction occurred the patient was quite well. In the first case, however, there were indigestion, tenderness and enlargement of the liver, rigor, and rise of temperature, with profuse sweating. Under chloroform a localized swelling was felt in the right hypochondrium, but this disappeared completely later. Neither hemorrhage nor tympanites was present in either case at any time. Post-mortem examination in the one case disclosed the presence of a gall stone impacted in the jejunum, it having escaped from the gall bladder into the first portion of the duodenum through an opening about one inch in diameter. In the second case the stone was passed after the injection of an enema. In both cases the vomit was copious and almost like pure bile, but toward the end it became slightly stercoraceous in the first. In neither was the pain of exceptionally severe character. In the fatal case the symptoms lasted ten days; in the other, two days.

Cant reports three additional cases of obstruction of the small intestine by a gall stone, occurring in a woman 65 years old, a man about 48, and a woman about 50, respectively. In the first, abdominal section was performed, and the calculus removed, but death ensued about a week after the operation. In the second also cœliotomy was performed and the stone removed, but death resulted shortly after the operation. Cœliotomy was likewise performed in the third case, in which recovery ensued. In two of the cases an attempt was made to break up the concretions with a needle, but without success. None of the patients had previously had symptoms of gall stones, but only bilious attacks; nor had they suffered from severe pain preceding the obsruction. The vomiting was at first of a marked bilious character, and gradually became stercoraceous.

## Bunion.

New York Medical Journal.

Parker Syms says the cause of this deformity of the foot is the wearing of shoes which are faulty in shape or are ill fitting. A shoe that crowds the toes together or pushes the great toe backwards will tend to produce this trouble. In this class are shoes with the following characteristics:

1. Shoes with narrow points, with the point in the median line.
2. Shoes that are too short.
3. Shoes that are so loose at the instep as to allow the foot to ride forward, and thus bring direct backward pressure on the toes.
4. The worst of all are shoes that combine two or all of these defects.

This deformity has been ascribed to osteo-arthritis, to suppurative arthritis, to rheumatism, and to gout; but bad shoes are its cause, and the arthritis is the result of the displacement they produce and of the injury they do to the joint.

The condition will vary a good deal in different instances. In mild cases there is but slight deflection of the toe outward, and little or no dislocation. From this stage or degree on the increased deformity is owing rather to pathological changes than to mechanical conditions. A chronic arthritis is established. The internal lateral ligament is stretched, the external one is contracted. The joint surfaces may become eroded or eburnated. The weakened support finally allows complete dislocation, so that the toe will lie at an angle, perhaps a right angle, across its fellows. The tendons will of course become displaced. Some surgeons have made the mistake of considering the displaced sesamoid bones (in the tendons of the flexor brevis) as the cause of the trouble and not as one of the results.

In operating the writer makes an incision about an inch in length on the dorsum of the toe. In a mild case, after retracting the tendon of the extensor proprius pollicis outward, he chisels off all the overprominent portion of the inner side of the head of the metatarsal bone, removing as much bone as

is necessary to do away with all protuberance; he then sutures the wound and lets it heal under one dressing. Usually the patient can walk about after the first week.

In more severe cases where there is a marked abduction as well as lateral dislocation, Syms removes the head of the metatarsal with a chisel or bone forceps, and also cuts off the prominent inner side of that bone. To resect the head of the metatarsal bone it will be necessary to divide the lateral ligaments and completely dislocate the toe. This can be done with ease and satisfaction through the simple straight incision described. It is necessary to remove so much bone that the toe will readily come into place and have no tendency to displacement. If this is not accomplished by the first ablation more bone must be removed.

The dressing must be carefully done and close attention given to the after treatment, which should include the application of a plaster splint. The writer advises never to operate during an acute attack of inflammation; always treat the deformity and never operate on the bursa for it will take care of itself after its cause is removed—the exceptions to this rule are the removal of callosities from the bursa when they exist, and the incision of bursæ when they suppurate; never to make the operation incision around or through the bursa.

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## Continued Good Results.

The January, 1894, number of *The Quarterly Journal of Inebriety*, published under the auspices of the American Association for the Study and Cure of Inebriates, Hartford, Conn., says through its able editor, T. D. Crothers, A.M., M.D.: Antikamnia is one of the best remedies in influenza, and in many instances is very valuable as a mild narcotic in neuralgias from alcohol and opium excesses. We have used it with best results." In a letter of more recent date to The Antikamnia Medical Company, Dr. Crothers writes: "Antikamnia continues to improve in value and usefulness, and we are using it freely."

The *Edinburgh Medical Journal*—Scotland—says, regarding Antikamnia: "In doses of three to ten grains it appears to act as a speedy and effective antipyretic and analgesic."

The *Medical Annual*, London, England, says: "Our attention was first called to this analgesic by an American physician whom we saw in consultation regarding one of his patients suffering from locomotor ataxia. He told us that nothing had relieved the lightning pains so well as antikamnia, which at that time was practically unknown in England. We have since used it repeatedly for the purpose of removing pain with most satisfactory results. The average dose is only five grains, which may be repeated without fear of unpleasant symptoms."

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## Treatment of Consumption by Cinnamon.

Thompson in British Medical Journal.

It appears probable that the oil of cinnamon cures consumption in two ways: In the early stages of catarrhal phthisis, by so directly affecting the bacilli as to stop their growth: In cases that are rather far advanced, by only allowing organisms incapable of growth to pass along the bronchi, and thus prevent the infection of fresh lobules. In this way the disease may be limited to small areas, where it can be dealt with by the vital processes of the body, and cut off from the system by the formation of fibrous tissue, and so cease to be an immediate source of danger. An interesting feature in the cases observed under this treatment was the order in which the symptoms subsided. The expectoration and the cough were the first to improve, then the temperature tended to the normal, and finally the weight began to increase. These favorable changes were accompanied by gradual diminution in the number of the bacilli in the sputum.

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DR. J. M. FRANKENBURGER, of Kansas City, Mo., spent Christmas in Topeka.